Title 8, California Code of Regulations
Chapter 4.5
Subchapter 1
Administrative Director – Administrative Rules
Article 2
Disabilities, Description of

§ 9725. Method of Measurement.

The method of measuring physical elements of a disability should follow the Report of the Joint Committee of the California Medical Association and Industrial Accident Commission, as contained in *"Evaluation of Industrial Disability"* edited by Packard Thurber, Second Edition, Oxford University Press, New York, 1960. This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 4660, 4662, 4663, 4664, Labor Code.

§ 9726. Method of Measurement (Psychiatric).

The method of measuring the psychiatric elements of a disability shall follow the Report of the Subcommittee on Permanent Psychiatric Disability to the Medical Advisory Committee of the California Division of Industrial Accidents, entitled "The Evaluation of Permanent Psychiatric Disability," (hereinafter referred to as the "Psychiatric Protocols") as adopted, forwarded for adoption on July 10, 1987, and subsequent amendments and/or revisions thereto adopted after a public hearing. This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 4660, 4662, 4663, and 4664, Labor Code.

§ 9727. Subjective Disability.

Subjective Disability should be identified by:

1. A description of the activity which produces the disability.

2. The duration of the disability.

3. The activities which are precluded and those which can be performed with the disability.

4. The means necessary for relief. The terms shown below are presumed to mean the following:

1. A *severe* pain would preclude the activity precipitating the pain.

2. A *moderate* pain could be tolerated, but would cause marked handicap in the performance of the activity precipitating the pain.

3. A *slight* pain could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.

4. A *minimal* (mild) pain would constitute an annoyance, but causing no handicap in the performance of the particular activity, would be considered as nonratable permanent disability.

This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 4660, 4662, 4663, 4664, Labor Code.

Article 5
Transfer of Medical Treatment

§ 9785. Reporting Duties of the Primary Treating Physician.

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer or the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(3) "Claims administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and

extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) "Future medical treatment" is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) "Permanent and stationary status" is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§ 4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, or if the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4061 and 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4610, 4061 and 4062.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code Section 4636(b);

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (Form PR-3) contained in Section 9785.3, or in such other manner ~~as~~ which provides all the information required by Title 8, California Code of Regulations, ~~S~~section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use Form PR-3 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.
Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4636, 4660, 4662, 4663, and 4664, Labor Code.

§9785.2 Form PR-2 "Primary Treating Physician's Progress Report"

State of California Additional pages attached ?
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box (es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization ☐ Other:

Patient:
Last _____First _____M.I._____Sex _____
Address_____City_____ State _____Zip_____
Date of Injury_____ Date of Birth_____
Occupation_____SS # _____-_____-_____ Phone (___)_____
Claims Administrator:
Name_____ Claim Number_____
Address_____City_____ State_____Zip_____
Phone (___) _____ FAX (_____) _____

Employer name: Employer Phone ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:
1. _____ ICD-9 _____
2. _____ ICD-9 _____
3. _____ ICD-9 _____

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider**.** Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

Work Status: This patient has been instructed to:
☐ Remain off-work until_____.
☐ Return to *modified* work on_____ with the following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

§9785.2 Form PR-2 "Primary Treating Physician's Progress Report"

State of California Additional pages attached ?
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

☐ Return to full duty on _____with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: _____

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature:_____Cal. Lic. # _____
Executed at:_____Date: _____
Name: _____Specialty: _____
Address: _____Phone: _____

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.
Reference: Sections 4061.5, 4600, 4603.2, 4610, 4636, 4660, 4662, 4663, and 4664, Labor Code.

§9785.3 Form PR-3 "Primary Treating Physician's Permanent and Stationary Report"

STATE OF CALIFORNIA

Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

This form is required to be used for ratings prepared pursuant to the 1997 Permanent Disability Rating Schedule. It is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient:

Last Name_____ Middle Initial ____ First Name _____Sex ___ Date of Birth _____

Address _____City _____ State _____ Zip _____

Occupation _____ Social Security No. _____ Phone No. _____

Claims Administrator/Insurer:

Name _____Claim No. _____ Phone No. _____

Address _____City _____ State _____ Zip _____

Employer:

Name _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury_____ Last date _____ Date of current _____Permanent & _____

Date worked Date examination Date Stationary date Date

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

Relevant Medical History:

Objective Findings:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range of motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

Diagnoses (List each diagnosis; ICD-9 code must be included) ICD-9

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

	Yes	No	Cannot determine
Can this patient now return to his/her usual occupation?	✍	✍	✍
If not, can the patient perform another line of work?	✍	✍	✍

Subjective Findings: Provide your professional assessment of the subjective factors of disability, based on your evaluation of the patient's complaints, your examination, and other findings. List specific symptoms (e.g. pain right wrist) and their frequency, severity, and/or precipitating activity using the following definitions:

Severity: Minimal pain - an annoyance, causes no handicap in performance.
Slight pain - tolerable, causes some handicap in performance of the activity precipitating pain.
Moderate pain - tolerable, causes marked handicap in the performance of the activity precipitating pain.
Severe pain - precludes performance of the activity precipitating pain.

Frequency: Occasional - occurs roughly one fourth of the time.
Intermittent - occurs roughly one half of the time.
Frequent - occurs roughly three fourths of the time.
Constant - occurs roughly 90 to 100% of time.

Precipitating activity: Description of precipitating activity gives a sense of how often a pain is felt and thus may be used with or without a frequency modifier. If pain is constant during precipitating activity, then no frequency modifier should be used. For example, a finding of "moderate pain on heavy lifting" connotes that moderate pain is felt whenever heavy lifting occurs. In contrast, "intermittent moderate pain on heavy lifting" implies that moderate pain is only felt half the time when engaged in heavy lifting.

		Yes	No	Cannot determine
Pre-Injury Capacity	Are there any activities at home or at work that the patient cannot do as well now as could be done prior to this injury or illness?	✍	✍	✍

If yes, please describe pre-injury capacity and current capacity (e.g. used to regularly lift a 30 lb. child, now can only lift 10 lbs.; could sit for 2 hours, now can only sit for 15 mins.)

1.

2.

3.

4.

Preclusions/Work Restrictions

	Yes	No	Cannot determine
Are there any activities the patient cannot do?	☐	☐	☐

If yes, please describe all preclusions or restrictions related to work activities (e.g. no lifting more than 10 lbs. above shoulders; must use splint; keyboard only 45 mins. per hour; must have sit/stand workstation; no repeated bending). Include restrictions which may not be relevant to current job but may affect future efforts to find work on the open labor market (e.g. include lifting restriction even if current job requires no lifting; include limits on repetitive hand movements even if current job requires none).

1.

2.

3.

4.

5.

6.

Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) Also, describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

Comments:

Apportionment:

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	✍	✍
Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness?	✍	✍

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

Written Job Description:

Other:

STATE OF CALIFORNIA

Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature: _____ Cal. Lic. # : _____

Executed at: _____ Date: _____

(County and State)

Name (Printed): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.
Reference: Sections 4600, 4061.5, 4603.2, 4636, 4660, 4662, 4663, and 4664, Labor Code.

§9785.4 Form PR-4 "Primary Treating Physician's Permanent and Stationary Report"

STATE OF CALIFORNIA

Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

This form is required to be used for ratings prepared pursuant to the 2005 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.). It is designed to be used by the primary treating physician to report the initial evaluation of permanent ~~disability~~ impairment to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient:

Last Name_____ Middle Initial ____ First Name _____Sex ____ Date of Birth _____

Address _____City _____State _____ Zip _____

Occupation _____ Social Security Number _____ Phone No. _____

Claims Administrator/Insurer:

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Employer:

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Treating Physician:

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury_____ *Date* Last date worked _____ *Date* Permanent & Stationary date _____ *Date* Date of current examination _____ *Date*

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Relevant Medical History:

Objective Findings:

Physical Examination: Describe all relevant findings as required by the AMA Guides, 5th Edition. Include any specific measurements indicating atrophy, range of motion, strength, etc. Include bilateral measurements - injured/uninjured - for injuries of the extremities.

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

Diagnoses (List each diagnosis; ICD-9 code must be included) ICD-9

1. _____
2. _____
3. _____ _____
4. _____ _____

Impairment Rating:
Report the whole person impairment (WPI) rating for each impairment using the AMA Guides, 5th Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			

Pain assessment:

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA Guides, 5th Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

Apportionment:

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

	Yes	No
Is the permanent disability directly caused, by an injury or illness arising out of and in the course of employment?	✍	✍
Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness?	✍	✍

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

Future Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc.

Comments:

Functional Capacity Assessment:

Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not to be considered in the permanent ~~disability~~ impairment rating.

Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:

[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.

FREQUENTLY LIFT and/or CARRY:

[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.

OCCASIONALLY LIFT and/or CARRY:

[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.

STAND and/or WALK a total of:

[ ] Less than 2 HOURS per 8 hour day
[ ] Less than 4 HOURS per 8 hour day
[ ] Less than 6 HOURS per 8 hour day
[ ] Less than 8 HOURS per 8 hour day

SIT a total of:

[ ] Less than 2 HOURS per 8 hour day
[ ] Less than 4 HOURS per 8 hour day
[ ] Less than 6 HOURS per 8 hour day
[ ] Less than 8 HOURS per 8 hour day

PUSH and/or PULL (including hand or foot controls):

[ ] UNLIMITED

[ ] LIMITED (Describe degree of limitation)

ACTIVITIES ALLOWED:

	Frequently	Occasionally	Never
Climbing	[ ]	[ ]	[ ]
Balancing	[ ]	[ ]	[ ]
Stooping	[ ]	[ ]	[ ]
Kneeling	[ ]	[ ]	[ ]
Crouching	[ ]	[ ]	[ ]
Crawling	[ ]	[ ]	[ ]
Twisting	[ ]	[ ]	[ ]
Reaching	[ ]	[ ]	[ ]
Handling	[ ]	[ ]	[ ]
Fingering	[ ]	[ ]	[ ]
Feeling	[ ]	[ ]	[ ]
Seeing	[ ]	[ ]	[ ]
Hearing	[ ]	[ ]	[ ]
Speaking	[ ]	[ ]	[ ]

Describe in what ways the impaired activities are limited:

Environmental restrictions (e.g. heights, machinery, temperature extremes, dust, fumes, humidity, vibration etc.)

	Yes	No
Can this patient now return to his/her usual occupation?	✍	✍

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

Written Job Description:

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Other:

Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature : Cal. Lic. # : _____

Executed at : Date: _____

(County and State)

Name (Printed) : Specialty: _____

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 4600, 4061.5, 4603.2, 4636, 4660, 4662, 4663, and 4664, Labor Code.

Article 7
Schedule for Rating Permanent Disabilities

§ 9805. Schedule for Rating Permanent Disabilities, Adoption, Amendment.

The method for the determination of percentages of permanent disability is set forth in the Schedule for Rating Permanent Disabilities, which has been adopted by the Administrative Director effective January 1, 2005, and which is hereby incorporated by reference in its entirety as though it were set forth below. The schedule adopts and incorporates the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment 5th Edition*. The schedule shall be effective for dates of injury on or after January 1, 2005~~,~~ and for dates of injury prior to January 1, 2005, in accordance with subdivision (d) of Labor Code section 4660, and it shall be amended at least once every five years.

The schedule may be downloaded from the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/dwcrep.htm.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 4660, 4662, 4663, and 4664, Labor Code.

§9805.1 Data Collection, Evaluation, and Revision of Schedule

The Administrative Director shall: (1) collect for 18 months permanent disability ratings under the 2005 Permanent Disability Rating Schedule (PDRS) effective for injuries occurring on or after 1/1/05 and effective for injuries occurring on or after 4/19/04 and before 1/1/05 where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Labor Code Section 4601 to the injured employee; (2) evaluate the data to determine the aggregate effect of the diminished future earning capacity adjustment on the partial permanent disability ratings under the 2005 PDRS; and (3) revise, if necessary, the diminished future earning capacity adjustment to reflect consideration of an employee's diminished future earning capacity for injuries based on the data collected. If the Administrative Director determines that there is not a sufficient amount of data to perform a statistically valid evaluation, the Administrative Director shall continue to collect data until a valid statistical sample is obtained. If there is a statistically valid sample of data that the Administrative Director determines supports a revision to the diminished future earning capacity adjustment, the Administrative Director shall revise the PDRS before the mandatory five year statutory revision contained in Labor Code section 4660(c).

Authority: Sections 133, and 5307.3, Labor Code
Reference: Sections 4660, 4662, 4663, and 4664, Labor Code

Subchapter 1.6
Permanent Disability Rating Determination

§ 10150. Disability Evaluation Unit.

The Disability Evaluation Unit, under the direction and authority of the Administrative Director, will issue permanent disability ratings as required under this subchapter utilizing the Schedule for Rating Permanent Disabilities adopted by the Administrative Director. The Disability Evaluation Unit will prepare the following kinds of rating determinations:

(a) Formal rating determinations

(b) Summary rating determinations

(c) Consultative rating determinations

(d) Informal rating determinations.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4660, 4662, 4663, and 4664, Labor Code.

~~§ 10151. Schedule for Rating Permanent Disabilities.~~

§ 10152. Disability, When Considered Permanent

A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4061, 4062, 4062.01, 4062.1, 4660, 4662, 4663, and 4664, Labor Code.

§ 10156. Formal Rating Determinations.

A formal rating determination will be prepared by the Disability Evaluation Unit ~~on~~ when requested by the Appeals Board or a Workers' Compensation Judge on a form specified for that purpose by the Administrative Director. The form will provide for a description of the disability to be rated, the occupation of the injured employee, the employee's age at the time of injury, the date of injury, the formula used, and a notice of submission in accordance with Appeals Board Rules of Practice and Procedure.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4660, 4662, 4663, and 4664, and 5701, Labor Code.

§ 10158. Formal Rating Determinations As Evidence.

Formal rating determinations prepared by disability evaluators shall be deemed to constitute evidence only as to the relation between the disability or impairment standard(s) described and the percentage of permanent disability.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4660, 4662, 4663, and 4664, Labor Code.

§ 10160. Summary Rating Determinations, Comprehensive Medical Evaluation of Unrepresented Employee.

(a) The Disability Evaluation Unit will prepare a summary rating determination upon receipt of a properly prepared request. A properly prepared request shall consist of:

(1) A completed Request for Summary Rating Determination, DEU Form 101;

(2) A completed Employee's ~~Permanent~~ Disability Questionnaire, DEU Form 100;

(3) A comprehensive medical evaluation of an unrepresented employee from a Qualified Medical Evaluator.

(b) The insurance carrier or self-insured employer shall provide the employee with an Employee's ~~Permanent~~ Disability Questionnaire (DEU Form 100) prior to the appointment scheduled with the Qualified Medical Evaluator. The employee will be instructed in the form and manner prescribed by the Administrative Director to complete the questionnaire and provide it to the Qualified Evaluator at the time of the examination.

(c) The insurance carrier, self-insured employer or injured worker shall complete a Request for Summary Rating Determination (DEU Form 101), a copy of which shall be served on the opposing party. The requesting party shall send the request, including proof of service of the request on the opposing party, to the Qualified Medical Evaluator together with all medical reports and medical records relating to the case prior to the scheduled examination with the Qualified Medical Evaluator. The request shall include the appropriate address of the Disability Evaluation Unit. A listing of all of the offices of the Disability Evaluation Unit, with each office's area of jurisdiction, will be provided, upon request, by any office of the Disability Evaluation Unit or any Information and Assistance Office.

(d) When a summary rating determination has been requested, the Qualified Medical Evaluator shall submit all of the following documents to the Disability Evaluation Unit at the location indicated on the DEU Form 101 and shall concurrently serve copies on the employee and claims administrator:

1. Request for Summary Rating Determination of Qualified Medical Evaluator's Report (DEU Form 101) as a cover sheet to the evaluation report;

2. Employee's ~~Permanent~~ Disability Questionnaire (DEU Form 100);

3. Comprehensive medical evaluation by the Qualified Medical Evaluator, including the Qualified Medical Evaluator's Findings Summary Form (IMC Form 1002).

(e) No request for a summary rating determination will be considered to be received until the DEU Form 100, the DEU Form 101, and the comprehensive medical evaluation have been received by the office of the Disability Evaluation Unit having jurisdiction over the employee's area of residence. In the event an employee does not have a completed Employee's ~~Permanent~~ Disability Questionnaire (DEU Form 100) at the time of his or her appointment with a Qualified Medical Evaluator, the medical evaluator shall provide this form to the employee for completion prior to the evaluation. Any requests received on or after April 1, 1994 without all the required documents will be returned to the sender.

(f) Any request for the rating of a supplemental comprehensive medical evaluation report shall be made no later than twenty days from the receipt of the report and shall be accompanied by a copy of the correspondence to the evaluator soliciting the supplemental evaluation, together with proof of service of the correspondence on the opposing party.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663, and 4664, Labor Code.

§ 10161. Forms

(a) Employee's ~~Permanent~~ Disability Questionnaire (DEU Form 100) (revised ~~1/95~~ 4/05).

(b) Request for Summary Determination of Qualified ~~or Agreed~~ Medical ~~Examiner's~~ Evaluator's Report (DEU Form 101) (revised ~~1/95~~ 4/05).

(c) Request for Summary Determination of Primary Treating Physician's Report (DEU Form 102)

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663, and 4664, Labor Code.

STATE OF CALIFORNIA
Division of Workers' Compensation
Disability Evaluation Unit
DEU Form 100 (Rev. 4/05)

EMPLOYEE'S ~~PERMANENT~~ DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee	Employer
Social Security No.	Nature of employer's business
Street and Number	
City, State, Zip Code	Claim number
Date of Injury	Date of Birth

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY, using reverse side if needed:

How was your evaluating doctor selected? (check one)

From a list of doctors provided by the State of California, ~~Industrial Medical Council~~ Division of Workers' Compensation.

~~From a list of doctors provided by the State of California, Information and Assistance Unit.~~

Other (explain)_____

What is the name of the doctor who will be doing the evaluation?_____

When is your examination scheduled?_____

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this ~~disability~~ injury affect you in your work?

Have you ever had a ~~permanent~~ disability as a result of another injury or illness? If so, when?_____

Please describe the disability?_____

Sign here _____Date: _____

~~DEU FORM 100 (REV. 2/95)~~

REQUEST FOR SUMMARY RATING DETERMINATION
of Qualified ~~or Agreed~~ Medical ~~Examiner's~~ Evaluator's Report
State of California
Division of Workers' Compensation
Disability Evaluation Unit
DEU Form 101 (Rev. 4/05)
~~To be used for dates of injury on or after 1/1/91~~

DEU Use Only

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
~~1~~2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
~~2~~3. ~~If the employee is unrepresented, be sure to s~~Send the EMPLOYEE'S ~~PERMANENT~~ DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
~~3~~4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee's ~~Permanent~~ Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. **PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. ~~If the employee is unrepresented, s~~Serve a copy of your report and the Form 100 upon the claims administrator and the employee. ~~If the employee is represented, serve a copy of your report on the party or parties requesting the evaluation only.~~

Date of first medical report indicating the existence of permanent impairment or disability: _____
Last date for which temporary disability indemnity was paid: _____

SUBMIT TO: DISABILITY EVALUATION UNIT
Mailing Address:
City, State, Zip:

CLAIMS ADMINISTRATOR
Company:
Mailing Address:
City, State, Zip:
Claim No:
Phone No:
Adjustor:
EMPLOYER:

PHYSICIAN:
EXAM DATE:

EMPLOYEE
Name:
Mailing Address:
City, State, Zip:
Date of Injury:
Date of Birth:
Social Security #:
WCAB Case No. (if any):
~~Representative's name (if any):~~
~~Representative's address:~~

OCCUPATION: _____
(Please attach job description or job analysis, if available)

WEEKLY GROSS EARNINGS: _____ (Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)

PROOF OF SERVICE BY MAIL

On _____, I served a copy of this Request for Summary Rating Determination on
(date)
_____ at _____ by
placing
(name of employee) *(address)*
a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature _____

~~DEU FORM 101 (REV. 2/95)~~

§ 10163. Apportionment Referral
(DEU Form 105)

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
DISABILITY EVALUATION UNIT

Date: _____

TO: Presiding Workers' Comp. Judge, _____
(Office)

FROM: Disability Evaluation Unit, _____
(Office)

SUBJECT: DEU File:
Employee:
QME:
Date of Report:

The attached formal medical evaluation report indicates that part or all of the permanent disability may be subject to apportionment pursuant to Labor Code Section 4663 and/or Labor Code Section 4664. Please determine whether the apportionment is inconsistent with the law.

If you believe the apportionment is inconsistent with the law, you may refer the report back to the medical evaluator for correction or clarification. If you receive no response from the medical evaluator within 30 days from your request, please make your determination based on the original report.

After checking the appropriate space, sign and date the bottom of this form and return it with the medical report to the DEU office listed above.

Thank you.

The apportionment: IS CONSISTENT _____ or
IS NOT CONSISTENT _____ with the law.

_____, **Workers' Compensation Judge**
(Signature)

_____
(Date)

NOTE: This memorandum is an administrative document and is not admissible in any judicial proceeding.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4660, 4662, 4663, and 4664, Labor Code.

§10165.5. Notice of Options Following
~~Permanent~~ Disability Rating~~)~~
(DEU Form 110)

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
DISABILITY EVALUATION UNIT

NOTICE OF OPTIONS FOLLOWING ~~PERMANENT~~ DISABILITY RATING

This is a ~~permanent~~ disability rating determination (Rating) prepared by the State of California Disability Evaluation Unit within the Division of Workers' Compensation. It describes your percentage of ~~permanent~~ disability. This percentage is based on your limitations as reported by the doctor, your potential loss of future earning capacity, your age, and the type of work you were doing at the time of your injury. If the rating indicates that you have some permanent disability, you should automatically begin to receive permanent disability payments. Payments are made in installments, every two weeks, for the number of weeks shown on the rating, less any permanent disability payments made to you prior to the rating.

If the rating is not disputed by you or your employer, you do not have to take any action to receive your benefits. We do want you to know that you may have two options you may want to consider. They are:

1) STIPULATED FINDINGS AND AWARD;
2) COMPROMISE AND RELEASE;

1) STIPULATED FINDINGS AND AWARD

If you and the employer, carrier or agent, accept the rating, written agreements may be submitted to the Workers' Compensation Appeals Board (WCAB) requesting that an Award be made without the need for a hearing. We recommend this option when the rating is not disputed, and you have a need for future medical care. A Workers' Compensation Judge will review the stipulations and issue an award.

ADVANTAGES

? A stipulated award is a quick, easy way to settle your case while protecting your rights;
? There is no need to take time off work to go to a hearing;
? The Division of Workers' Compensation will review the settlement to protect your rights at no cost to you; there is no need to hire a lawyer;
? If your condition worsens, you can apply for additional payments anytime within five years from the date of your injury;
? If you need additional medical care or you are to receive a life pension (rating of 70% or more), your rights to future benefits can be fully protected and a judge can enforce the award if there later becomes a problem.

? You may request a lump sum payment of all or part of your permanent disability if you can show a financial need or hardship. However, a Workers' Compensation Judge must first be convinced that it would be in your best interest.

DISADVANTAGES

? You normally will not receive a lump sum payment, but will receive your benefits in payments every two weeks.

2) COMPROMISE AND RELEASE

A Compromise and Release Agreement is a settlement which usually permanently closes all aspects of a workers' compensation claim except for vocational rehabilitation benefits, including any provision for future medical care.

The Compromise and Release is paid in one lump sum to you. It must be reviewed and approved by a Workers' Compensation Judge.

ADVANTAGES

? You may receive more money than you would receive under a Stipulated Findings and Award because you are giving up your future rights in exchange for money.
? If the employer or insurance company disputes the rating, a Compromise and Release will assure you receive an agreed amount of money now rather than risk getting nothing or a lesser amount later.
? You will receive your benefits in one lump sum.

DISADVANTAGES

? A Compromise and Release usually permanently releases the employer from all future responsibilities. After your case has been resolved by a Compromise and Release Agreement, you cannot ask for more medical treatment at your employer's expense, nor can you claim additional benefits if your disability or condition becomes worse. Also, if you later die as a result of the injury, your dependents would not be entitled to death benefits.
? Once a Workers' Compensation Judge has approved your Compromise and Release, the settlement is final and it cannot be set aside except in very rare circumstances.

If you would like more information, you can receive recorded information free of charge, by calling 1-800-736-7401 or you may contact your local Information and Assistance officer (listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation). You may also consult an attorney of your choice.

SPECIAL NOTICE TO UNREPRESENTED INJURED WORKERS

If you disagree with the rating because you believe that the rating was improperly calculated or that the doctor failed to address any or all issues or failed to properly rate your impairment, you

may request administrative review of the rating within 30 days of receipt of the rating, from the Administrative Director of the Division of Workers' Compensation. In some cases, you may be entitled to an additional medical evaluation or a different medical specialist. Your request should include a copy of the rating and a copy of the report from the doctor. A copy of the request must be sent to your claims adjustor.

If you have questions about whether to request administrative review of your rating or whether another medical evaluation is appropriate, you should contact the local Information and Assistance Officer listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. They can tell you how to file the request if you decide to do so.

Authority: Sections 133, and 5307.3, Labor Code.
Reference: Sections 124, 4061, 4660, 4662, 4663, and 4664, Labor Code.